

2340

CERTIFICATE OF DEATH

02334

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILDRED AMELIA BEAUVAIS</u>				4. DATE OF DEATH Month Day Year <u>FEB. 18 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 28, 1904</u>	
				9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRESS STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM PENNYWELL</u>				14. MOTHER'S MAIDEN NAME <u>EVA GRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MR. RAYMOND BEAUVAIS, BERLIN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lungs</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Berlin Worcester Md</u>	
				20f. (City or town) <u>Berlin</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Dec 6, 1955</u> , to <u>Feb 18, 1956</u> , that I last saw the deceased alive on <u>Feb 17, 1956</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas R. Law</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u>			
DATE SIGNED <u>Feb 20-56</u>							
PHYSICIAN'S NAME (Type) <u>Charles R. Law</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE 2-24-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>William F. Hayward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
William Benjamin		M		21		1934		Arkansas		Arkansas		Heart Disease		Feb 27		1956		Arkansas		[Signature]		[Signature]	
Mr. William Benjamin		F		21		1934		Arkansas		Arkansas		Heart Disease		Feb 27		1956		Arkansas		[Signature]		[Signature]	
Mrs. William Benjamin		F		21		1934		Arkansas		Arkansas		Heart Disease		Feb 27		1956		Arkansas		[Signature]		[Signature]	
Mr. William Benjamin		M		21		1934		Arkansas		Arkansas		Heart Disease		Feb 27		1956		Arkansas		[Signature]		[Signature]	
Mrs. William Benjamin		F		21		1934		Arkansas		Arkansas		Heart Disease		Feb 27		1956		Arkansas		[Signature]		[Signature]	

BUREAU V. S.

FEB 27 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2341

CERTIFICATE OF DEATH

02335

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Snow Hill</u>		<u>Most of life</u>		TOWN <u>Snow Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>305 Willow Street</u>				STREET ADDRESS (If rural give location) <u>305 Willow Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Jennie Drumgo</u>				<u>2 - 2 - 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>A.A.</u>	<u>Married</u>	<u>10-14-1912</u>	<u>43</u> yrs.	<u>3</u> Months	<u>18</u> Days	<u></u> Hours <u></u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Poultry Plant</u>		<u>Littleton, North Carolina</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Watson</u>				<u>Nellie Kerney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Snow Hill, Md.</u>			
		<u>219-03-7679</u>		<u>Cager Drumgo, 308 Willow Street</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>443X</u> IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>				<u>8 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertensive Cardio-vascular Disease</u>				<u>6 mo</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Nephritis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/24</u>, 19<u>56</u>, to <u>2/2</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/2</u>, 19<u>56</u>, and that death occurred at <u>1:00 P.</u>M. from the causes and on the date stated above.							
SIGNATURE <u>Mary U. Luby, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Berlin, Md.</u>		DATE SIGNED <u>2-4-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-5-1956</u>		<u>Baptist Cemetery</u>		<u>Snow Hill, Worcester Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>FEB 6 1956</u>		<u>Blagen Cooper</u>		<u>J. F. Stewart</u> <u>Mary A. Stewart</u> <u>Funeral Home, Salisbury, Md.</u>			

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1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03436

2342

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Snow Hill</i>		LENGTH OF STAY (If this place) <i>91 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Snow Hill</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Laura M. Dwyer</i>				4. DATE OF DEATH (Month) <i>Feb</i> (Day) <i>12</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Sept. 17-1864</i>	9. AGE last birthday <i>91 1/4/25 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Snow Hill, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Edward Mainer</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Dwyer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, draft.) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Mrs Winnie D. Wall, Wilmington, Del.</i>		
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>				<i>2 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardio-</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>vascular renal disease</i>				<i>20 yr</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1946</i> , 19....., to <i>2/12/56</i> , 19....., that I last saw the deceased alive on <i>2/12/56</i> , 19....., and that death occurred at <i>5:30 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Paul Cohen</i> M.D.				ADDRESS (Street, city, town, state) <i>Snow Hill, md</i>		DATE SIGNED <i>2/13/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Feb 16/56</i>		NAME OF CEMETERY OR CREMATORY <i>Bethesda Methodist</i>		LOCATION (City, town, or county) (State) <i>Snow Hill, md</i>	
24. REC'D BY REGISTRAR DATE <i>Feb 16, 56</i>		REGISTRAR'S SIGNATURE <i>Clayton C. Pope</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter B. Dennis</i>		ADDRESS <i>Snow Hill, md</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. BIRTH TIME

8. BIRTH WEIGHT

9. BIRTH LENGTH

10. BIRTH HEAD CIRCUMFERENCE

11. BIRTH SKIN COLOR

12. BIRTH HAIR COLOR

13. BIRTH EYE COLOR

14. BIRTH MOUTH COLOR

15. BIRTH NOSE COLOR

16. BIRTH EAR COLOR

17. BIRTH FINGER COLOR

18. BIRTH TOE COLOR

19. BIRTH HEEL COLOR

20. BIRTH PALM COLOR

21. BIRTH SOLE COLOR

22. BIRTH NAIL COLOR

23. BIRTH SKIN CONDITION

24. BIRTH SKIN TEMPERATURE

25. BIRTH SKIN MOISTURE

26. BIRTH SKIN TENDRILS

27. BIRTH SKIN VESICLES

28. BIRTH SKIN BUBBLES

29. BIRTH SKIN CRACKS

30. BIRTH SKIN SCALDS

31. BIRTH SKIN BURNS

32. BIRTH SKIN LACERATIONS

33. BIRTH SKIN ABRASIONS

34. BIRTH SKIN CONTUSIONS

35. BIRTH SKIN LACERATIONS

36. BIRTH SKIN ABRASIONS

37. BIRTH SKIN CONTUSIONS

38. BIRTH SKIN LACERATIONS

39. BIRTH SKIN ABRASIONS

40. BIRTH SKIN CONTUSIONS

41. BIRTH SKIN LACERATIONS

42. BIRTH SKIN ABRASIONS

43. BIRTH SKIN CONTUSIONS

44. BIRTH SKIN LACERATIONS

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50. BIRTH SKIN LACERATIONS

51. BIRTH SKIN ABRASIONS

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98. BIRTH SKIN LACERATIONS

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100. BIRTH SKIN CONTUSIONS

BUREAU V. S.

MAR 21 1956

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ENCLOSURE

2343

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02336

Reg. Dist.

No. 353

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Showell</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Showell</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>rural</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print) (First) (Middle) (Last) <u>Charlie</u> <u>T. Harman</u>		(Month) (Day) (Year) <u>Feb</u> <u>29</u> <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>	8. DATE OF BIRTH: <u>1878</u>
9. AGE last birthday: <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Worcester Co. Md.</u>	
11. CITIZENSHIP: <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>_____</u>		14. MOTHER'S MAIDEN NAME: <u>_____</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>_____</u>	
17. INFORMANT & ADDRESS: <u>Viola Showell, Whaleyville, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>		?	
Antecedent cause(s) (b) <u>Coronary Heart Disease</u>		10 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Coronary Sclerosis</u>		10 yrs.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Atherosclerosis, Scurvy</u>		?	
19a. DATE OF OPERATION: <u>4/20/56</u>		19b. MAJOR FINDING OF OPERATION: <u>_____</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Showell Worcester, Md.</u>	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>_____</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>Herman Koblentz</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/2/56</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF: <u>3/3/56</u>	
NAME OF CEMETERY OR CREMATORY: <u>Whaleyville</u>		LOCATION (City, town, or county) (State): <u>Whaleyville Md.</u>	
DATE REC'D BY LOCAL REG.: <u>3-2-56</u>		24. FUNERAL DIRECTOR: <u>Herman Koblentz</u>	
REGISTRAR'S SIGNATURE: <u>Viola Showell</u>		ADDRESS: <u>Worcester Co. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Two for One, FilmG193 3-5-56 et

BUREAU V. S.

MAR 5 1956

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2338

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

COUNTY Worcester MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke LENGTH OF STAY (in this place) 3 month
 TOWN Pocomoke
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Belden Restorium 821-2nd Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Virginia COUNTY Accomack
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke 83X-3
 STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED:

(First) (Middle) (Last)
Susan Blanche Lewis

4. DATE (Month) (Day) (Year)
 OF DEATH Feb 10 1956

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

Oct 25-1881

9. AGE last birthday 74 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

Coun.

11. BIRTHPLACE (State or foreign country):

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

John J. Chandler

14. MOTHER'S MAIDEN NAME:

Catherine Sherwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

—

17. INFORMANT & ADDRESS:

Mrs. Cec. Carmine Pocomoke Va

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

IMMEDIATE CAUSE

(A) Pneumonia, Lobar

ANTECEDENT CAUSE (S):

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

5 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

1. Senility. 2. Hemiplegia 3. Arteriosclerosis

19A. DATE OF OPERATION:

0

19B. MAJOR FINDINGS OF OPERATION

—

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

☐

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

—

21C. WHERE DID (City or town) INJURY OCCUR?

—

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

—

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

—

21F. HOW DID INJURY OCCUR?

—

22. I hereby certify that I attended the deceased from Nov. 1, 1955, to Feb. 10, 1956 that I last saw the deceased

alive on Feb. 10, 1956, and that death occurred at 130 a.m. from the causes and on the date stated above.

SIGNATURE

Charles W. Trader

M. D.

ADDRESS

Pocomoke City Md. 2-1156

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Feb. 12-1956

NAME OF CEMETERY OR CREMATORY

Liberty Cemetery

LOCATION (City, town, or county)

Parkley Virginia

(State)

DATE REC'D BY LOCAL REGISTRAR

Feb. 12, 1956

REGISTRAR'S SIGNATURE

Anne E. White

24. FUNERAL DIRECTOR

Henry H. Watson

ADDRESS

Pocomoke Md.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 14 1956

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 350

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rural - Pocomoke City</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rural - Pocomoke City, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Washer Merrill farm</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Betty</u>	(Middle) <u>Anne</u>	(Last) <u>Schofield</u>	(Month) <u>2</u> (Day) <u>24</u> (Year) <u>1956</u>
5. SEX: <u>2</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>2-24-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	9. AGE last birthday: <u>7</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u>20</u> Min. <u>59</u>
13. FATHER'S NAME: <u>M. C. Kelton</u>		14. MOTHER'S MAIDEN NAME: <u>Hazel Francis Schofield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		17. INFORMANT & ADDRESS: <u>Stephen Schofield -</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>924.0</u> <u>Probably Suffocation (Accidental)</u>			
(b) Antecedent cause(s) <u>Over covered - Shutting off air supply</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>Baby lay down in bed with mother and under heavy covers</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Home</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. (City or town) (County) <u>Worc.</u> (State) <u>23</u>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>N. E. Gironio</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/24/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2/25/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Unionville</u>		LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 29, 1956</u>		24. FUNERAL DIRECTOR <u>Edgar Kinton - Newchurch, VA.</u>	
REGISTRAR'S SIGNATURE <u>Anne E. White</u>		ADDRESS	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 2 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2339

CERTIFICATE OF DEATH

Reg. Dist. No.

02339
350

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		d. STREET ADDRESS 451 Linden Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Post Office		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roger Middle F. Last Vincent		4. DATE OF DEATH Month February Day 21 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1889
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Frank Vincent		14. MOTHER'S MAIDEN NAME Alice Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Leta F. Vincent, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19, 1956, to Feb. 21, 1956, that I last saw the deceased alive on Feb. 21, 1956, and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader, M.D.		ADDRESS (Street, city or town, state) 302 Market, Pocomoke City, Md. DATE SIGNED Feb. 23, 1956	
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 24, 1956	
22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke, Md.	
24a. REC'D BY REGISTRAR DATE FEB 27 1956		24b. REGISTRAR'S SIGNATURE Anne White	

of the 1990s, and the 1990s have been a period of rapid growth in the number of people who are using the Internet.

BUREAU V. S.

FEB 27 1956

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